SENT VIA EMAIL OR FAX ON
Mar/17/2010

Independent Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE OF REVIEW:
Mar/01/2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Bilateral C4/5, C6/7 Medical Branch Block Facet Injections

DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board Certified in Physical Medicine and Rehabilitation
Subspecialty Board Certified in Pain Management
Subspecialty Board Certified in Electrodiagnostic Medicine
Residency Training PMR and ORTHOPAEDIC SURGERY

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)

[ ] Overturned (Disagree)

[ ] Partially Overturned (Agree in part/Disagree in part)

INFORMATION PROVIDED TO THE IRO FOR REVIEW
OD Guidelines
ADLs 12/30/09, 2/3/10
Physical Medicine and Rehab. 9/23/08
GENEX 2/26/09
Radiology 12/21/09
Pain 1/18/10, 12/9/09, 12/21/09
Peer Review 2/26/09

PATIENT CLINICAL HISTORY SUMMARY
This is a man injured on xx/xx/xx with a fall. He sustained multiple injuries, but the reviewer is directed to the neck. The DD exam in 9/08 commented upon cervical problems, but then

described minimal ones at the time. Dr. performed a peer review in 2/26/09 and noted degenerative changes at C5.6 and a broad based right paracentral disc protrusion at C6/7. Dr. and Ms saw him in December and January. They described local tenderness and limited cervical motion. An MRI done on 12/21/09 described multiple level degenerative changes with cervica facet arthropathy from C5 to C7, plus the disc bulge at C6/7. Dr. and Ms described plans for a transformainal ESI at the left C4/5 level and facet blocks.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

First, the ODG describes cervical facet pain and having local tenderness, reduced motion and no neurological loss or radicular complaints. It states the diagnosis required controlled blocks to avoid false positive blocks. The only indication of diagnostic facet blocks in the ODG is when a facet neurotomy (considered experimental) is being considered. The reviewer did not see that discussed as a treatment option in the records. Rather, the ESI for a radiculopathy was discussed. Therapeutic facet blocks are not considered appropriate. They can be done also in conjunction with planned therapies and later neurotomy. Neither were discussed. They are also not performed when there is any suggestion of a radiculopathy. The reviewer did not see where these requirements were met, therefore, the request is not medically necessary.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)